Health Care Glossary

Term	Definition
Access	A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and affordability of care.
Accessibility	As required by the Americans with Disabilities Act, removal of barriers that would hinder a person with a disability from entering, functioning, and working within a facility. Required restructuring of the facility cannot cause undue hardship for the employer.
Accessibility Of Services	Your ability to get medical care and services when you need them.
Accreditation	A process whereby a program of study or an institution is recognized by an external body as meeting certain predetermined standards. For facilities, accreditation standards are usually defined in terms of physical plant, governing body, administration, and medical and other staff. Accreditation is often carried out by organizations created for the purpose of assuring the public of the quality of the accredited institution or program. The state or federal governments can recognize accreditation in lieu of, or as the basis for licensure or other mandatory approvals. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent or may be given for a specified period of time.
Activities Of Daily Living (ADLs)	Basic self-care activities that are widely used as a basis for assessing individual functional status (including eating, bathing, dressing, transferring from bed to chair, bowel and bladder control, and independent ambulation).
Actual Charge	The amount of money a doctor, provider or supplier actually bills a patient for a particular medical service, procedure or supply. This amount is often more than the amount Medicare approves **(See Approved Amount, Assignment)**.
Acute Care	Medical treatment rendered to individuals whose illnesses or health problems are of a short-term or episodic nature – usually less than 3 months' duration.
Additional Drug Benefit List	A list of pharmaceutical products approved by a health plan and employer for dispensing in larger quantities than the standards covered under a benefit package in order to facilitate long-term patient use. Also called drug maintenance list.

Health Care Glossary

Term	Definition
Adjusted Average Per Capita Cost (AAPCC)	An estimate of how much Medicare will spend in a year for an average beneficiary **(See Risk Adjustment)**.
Adjusted Community Rating (ACR)	A system used to determine healthcare premium rates based on members' collective use of benefits rather than their individual use of benefits.
Administration on Aging (AoA)	An agency of the U.S. Department of Health and Human Services (HHS) that serves as an advocate agency for older persons and addresses their concerns at the federal level. AoA works closely with its nationwide network of state and Area Agencies on Aging (AAAs) to plan, coordinate, and develop community level systems of services that meet the unique needs of older persons and their caregivers. Address: U.S. Administration on Aging, Department of Health and Human Services, Washington, DC 20201; Phone: (202) 619-0724; Fax: (202) 357-3560; E-mail: aoainfo@aoa.gov; Website: http://www.aoa.gov.
Administrative Costs	Costs incurred by an insurance carrier for services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per member per month basis. Additional costs that are often expressed as administrative include those related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, quality assurance activities, medical libraries and risk management.
Admitting Physician	The doctor responsible for admitting a patient to a hospital or other inpatient health facility.

Health Care Glossary

Term	Definition
Adult Abuse Act	Arkansas Criminal Code § 5-28-101, which forbids abuse, exploitation and/or neglect of the elderly. **ABUSE IS:** 1) any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sexual abuse; or 2) any intentional or demeaning act which subjects an endangered or impaired adult to ridicule or psychological injury in a manner likely to provoke fear or alarm. **NEGLECT IS:** 1) negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered or impaired adult; 2) negligently failing to report health problems or changes in health problems or changes in the health condition of an endangered or impaired adult to the appropriate medical personnel; or 3) negligently failing to carry out a prescribed treatment plan. **EXPLOITATION IS:** the illegal use or management of an endangered or impaired adult's funds, assets, or property, or the use of an endangered or impaired adult's power of attorney or guardianship or person for the profit or advantage of himself or another.
Adult Day Care	A daytime community-based program for functionally impaired adults that provides a variety of health, social, and related support services in a protective setting, under the auspices of a health care facility or freestanding adult day care center, that allow a person to function in the home or provide respite for caregivers (including health, medical, psychological, social, nutritional, and educational services).
Advance Beneficiary Notice (ABN)	A notice that a doctor or supplier should give a Medicare beneficiary to sign if he or she believes that items or services provided will not be considered medically necessary or eligible for payment by Medicare. If you do not get an ABN to sign before you get the service from your doctor and Medicare does not pay for it, then you do not have to pay for it. If the doctor gives you an ABN that you sign before you get the service and Medicare does not pay for it, then you will have to pay your doctor for it.
Advance Coverage Decision	A decision that your Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.
Advance Directive (Health Care)	A document, written ahead of time, that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for Health Care (Ark Code Ann. § 20-13-104).

Health Care Glossary

Term	Definition
Advanced Life Support (ALS) Ambulance Services	Life support techniques that involve the use of special equipment such as defibrillators, and administration of oxygen, drugs or fluids.
Adverse Selection	A term used to describe a situation in which a carrier disproportionally enrolls a population which is prone to higher than average utilization of benefits, thereby driving up costs and increasing financial risk.
Affiliated Provider	A healthcare provider or facility that is paid by a health plan to provide services to plan members or subcontracted by a primary provider in order to gain additional services for its members.
Aftercare	Services following hospitalization or rehabilitation, individualized for each patient's needs. Aftercare gradually phases the patient out of treatment while providing follow-up attention to prevent relapse.
Aged	Persons ag 65 and older, as defined by government benefit programs.
Aid to Families with Dependent Children (AFDC)	A joint federal-state welfare program for low-income families. In all states, AFDC recipiency may be used to establish Medicaid eligibility. Now known as Temporary Assistance to Needy Families (TANF).
Air-Fluidized Bed	A Durable Medical Equipment (DME) device employing the circulation of filtered air through ceramic spherules (small, round ceramic objects) that is intended to treat or prevent bedsores, to treat severe or extensive burns, or to aid circulation. It uses warm air under pressure to set the small ceramic beads in motion. When the patient is placed in the bed, his body weight is evenly distributed over a large surface area, which creates a sensation of "floating." Medicare covers the cost, after all other alternative equipment has been ruled out, when: the patient has a stage 3 or 4 pressure sore; is bedridden or chair bound due to severely limited mobility; or would require institutionalization without it. A physician must prescribe the bed, direct the home treatment regimen, and re-evaluates and re-certify the need on a monthly basis.
Allied Health Professionals	Persons with special training in fields related to medicine, such as medical social work and physical or occupational therapy. Allied health professionals work with physicians or other health professionals.
Allowable Charge	The maximum fee that a third party will reimburse a provider for a given service. An allowable charge may not be the same amount as either a reasonable or customary charge.

Health Care Glossary

Term	Definition
Allowable Costs	Charges for services rendered or supplies furnished by a health provider that qualify for an insurance reimbursement. The maximum fee that a third party will reimburse a provider for a given service. Also, facility operating costs that are reimbursable by the state under the state Medicaid program.
Alternating Pressure Mattress	A mattress and pump, which is similar to the low air loss bed. There is no bed frame attached to this type of unit.
Alternative Care	Medical care received instead of inpatient hospitalization or accepted medical practices.
Alzheimer's Disease	A progressive, irreversible disease characterized by degeneration of the brain cells and servere loss of memory, causing the individual to become dysfunctional and dependent upon others for basic living needs.
Ambulatory Care	Health care or services that are provided on an outpatient basis, such as those delivered at a physician's office, clinic, medical center, or outpatient facility.
Ambulatory Surgical Center	A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.
Ancillary Charge	The fee associated with additional service performed prior to and/or secondary to a significant procedure, also referred to as hospital "extras" or miscellaneous hospital charges. They are supplementary to a hospital's daily room and board charge, and include charges for drugs, medicines and dressings, lab services, x-ray examinations, and use of the operating room.
Ancillary Services	Hospital or in-patient facility services other than room, board, and professional services. They may include X-rays, lab tests, drugs or anesthesia. Also, those services needed by a nursing home resident but not provided by a nursing home, such as podiatry or dentistry (i.e., costs that might not be included in the basic rate of the facility). They may, however, be included in the basic rate if they are part of the routine care for a person.
Annual Election Period	The Annual Election Period for Medicare beneficiaries is the month of November each year. Enrollment will begin the following January.
Antitrust	A legal term referring to a variety of efforts on the part of government to assure that sellers do not conspire to restrain trade or fix prices for their goods or services in the market.

Health Care Glossary

Term	Definition
Any Willing Provider	A requirement that a health insurance plan must sign a contract for the delivery of health care services with any provider in the area that is willing to provide such services to the plan's enrollees and can meet the terms of a contract.
Appeal	A formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment, or an administrative action.
Approved Amount	The amount Medicare determines to be reasonable for a service covered under Part B. It may be less than the actual amount charged. **(See Actual Charge, Assignment)**.
Area Agency on Aging (AAA)	A local agency established by the Older Americans Act of 1974 to "monitor, assess, coordinate and pool" all resources, public and private, which provide services to the growing population of persons over 60 years of age. In Arkansas there are eight Area Agencies on Aging (AAAs), each separately incorporated as a non-profit agency under Section 501(c)(3) of the IRS Code.
AAA Region I	**The AAA of Northwest Arkansas** (Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy and Washington) 1510 Rock Springs Rd, PO Box 1795, Harrison, AR 72602-1795 Phone: 870-741-1144; Toll free: 1-800-432-9721 TDD: 870-741-1346
AAA Region II	**White River AAA** (Cleburne, Fulton, Independence, Izard, Jackson, Sharp, Stone, Van Buren, White, and Woodruff) 3998 Harrison Street, PO Box 2637, Batesville, AR 72503 Phone: 870-612-3000; Toll free & TDD: 1-800-382-3205
AAA Region III	**East Arkansas AAA** (Clay, Craighead, Crittenden, Cross, Greene, Lawrence, Lee, Mississippi, Phillips, Poinsett, Randolph, and St. Francis) 2005 E. Highland/Fountain Sq., PO Box 5035, Jonesboro, AR 72403, Phone: 870-972-5980; Toll free: 1-800-467-3278
AAA Region IV	**Area Agency on Aging of Southeast Arkansas** (Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Grant, Jefferson and Lincoln) 709 East 8th Street, PO Box 8569, Pine Bluff, AR 71611 Phone: 870- 543- 6300; TDD and Toll Free: 1- 800- 264- 3260

Health Care Glossary

Term	Definition
AAA Region V	**CareLink, the Central Arkansas Area Agency on Aging** (Faulkner, Lonoke, Monroe, Prairie, Pulaski and Saline) 706 West 4th Street, PO Box 5988, North Little Rock, AR 72119 Phone: 501-372-5300/688-7437; Toll free & TDD: 1-800-482-6359
AAA Region VI	**Agency on Aging West Central Arkansas** (Clark, Conway, Garland, Hot Spring, Johnson, Montgomery, Perry, Pike, Pope and Yell) 905 W. Grand Avenue, Hot Springs, AR 71913 Phone: 501-321-2811; Toll free: 1-800-467-2170; TDD: (501) 321-2811
AAA Region VII	**Area Agency on Aging of Southwest Arkansas** (Calhoun, Columbia, Dallas, Hempstead, Howard, LaFayette, Little River, Miller, Nevada, Ouachita, Sevier and Union) 600 Columbia, 11E, PO Box 1863, Magnolia, AR 71754-1863 Phone: 870-234-7410; Toll free & TDD: 1-800-272-2127
AAA Region VIII	**Area Agency on Aging of Western Arkansas** (Crawford, Franklin, Logan, Polk, Scott and Sebastian) 524 Garrison, PO Box 1724, Fort Smith, AR 7290 Phone: 479-783-4500; Toll free: 1-800-320-6667
Arkansas Health Center or Benton Services Center (BSC)	A 350-bed psychiatric nursing home, formerly known as the Benton Services Center (BSC), licensed by the Office of Long-Term Care as a skilled nursing facility. It serves the elderly and persons with disabilities who require specialized services or programs that are not generally available through community nursing facilities. The program emphasizes the provision of services to special-need groups and individuals with cognitive dysfunction. Services are available to all Arkansans, provided individuals meet admission criteria.
Assignment	A method of billing Medicare where the provider agrees to bill Medicare directly for services and accept Medicare's allowed charge as payment in full. Medicare pays the provider directly. The provider can then bill the beneficiary for deductibles and co-insurance **(See Actual Charge, Approved Amount).**
Assignment of Benefits	A method where a patient requests that his/her benefits under an insurance claim be paid to some designated person or institution, usually a physician or hospital.

Health Care Glossary

Term	Definition
Assisted Living	A type of congregate living arrangement in which assisted living services are available as needed to residents. "Assisted living services" means housing, meals, laundry, socialization, transportation, one or more personal care services, and limited nursing services. In most cases, the residents pay a regular monthly rent. Then, they typically pay additional fees for the services provided. Arkansas has a Medicaid waiver for assisted living that pays for assisted living services for a limited number of Medicaid eligible individuals who meet nursing home admission criteria.
Assisted Living Facility (ALF)	Any building or buildings, section or distinct part of a building that provides assisted living services for a period exceeding 24 hours to more than three adult residents who are not relatives of the owner or administrator. Every resident shall have a written Health Care Service Plan developed to meet the needs and preferences of the resident or his/her responsible party through a negotiated process. ALFs in Arkansas must provide services to residents 24 hours a day, including 24-hour awake staff supervision and care, assistance in obtaining emergency care (this provision may be met with an agreement with an ambulance service, hospital or emergency services through 911), and medication assistance or monitoring. Each ALF shall meet requirements for a dietary manager (Ark Code Ann. §20-10-108).
Assistive Devices	Tools that enable individuals with disabilities to perform essential job functions (e.g., telephone headsets, adapted computer keyboards, enhanced computer monitors).
Authorized Representative (Representative Payee)	Any person that a Social Security beneficiary or Supplemental Security Income (SSI) recipient requests be given the right to represent him/her in any business with the Social Security Administration. Some people choose an attorney and others ask a family member or friend to provide this assistance. Sometimes AARP offers this as a volunteer service. All claimants of Social Security and SSI benefits have the right to have an authorized representative, and can formally designate that person for the Social Security Administration by completing the "Appointment of Representative" form (SSA-1966, 12/68). This form specifies the limit for fees to be charged by an authorized representative, outlines the penalties for charging an unauthorized fee, and defines conflicts of interest.
Average Manufacturer Price (AMP)	The average price paid to a U.S. drug company by wholesalers for retail pharmacies, after deducting customary prompt pay discounts.
Average Wholesale Price (AWP)	The published dollar value for a prescription drug. Because of negotiated discounts, wholesalers, retail pharmacies and other purchasers may not pay AWP.

Health Care Glossary

Term	Definition
Basic Life Support (BLS) Ambulance Services	Life support techniques used to maintain adequate ventilation and circulation without the use of any equipment until further medical assistance arrives. There are three basic elements, usually remembered as ABC – Airway, Breathing and Circulation.
Behavior Modification	Attempts to change those habits that bear on health status of a patient, such as diet, exercise, smoking, etc., especially through organized health education programs.
Behavioral Health Care	Assessment and treatment of mental illness and/or psychoactive substance abuse disorders.
Beneficiary	A person who has health insurance through the Medicare or Medicaid programs.
Benefit	Money or service provided by an insurance policy. In a health plan, benefits are healthcare services.
Benefit Maximum	The dollar limit for the total reimbursement of health care costs during a benefit period.
Benefit Package	Services an insurer, government agency, or health plan offer to a group or individual under the terms of a contract.
Benefit Period	A way of limiting and measuring the claimant's use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have **(See Deductible, Skilled Nursing Facility)**.
Best Price	For purposes of Medicaid rebate calculations, the lowest price paid for a product by any purchaser other than federal agencies and state pharmaceutical assistance programs.
Bilevel Positive Airway Pressure machine (BiPAP)	A machine used to treat obstructive sleep apnea that provides air pressure that varies during each breath cycle. When the user inhales, the pressure is similar to that provided by a Continuous Positive Airway Pressure machine (CPAP). When the user exhales, the pressure drops, making it much easier to breathe. These machines are commonly prescribed for patients who have difficulty tolerating CPAPs.

Health Care Glossary

Term	Definition
Blue Book (MDBT)	The generic name for a widely used pricing guide entitled the "American Druggist First Databank Annual Directory of Pharmaceuticals." Brand name and generic drugs are listed by product, manufacturer, National Drug or Universal Price Codes, direct price, and average wholesale price (AWP). Other pricing guides are the Red Book and Medispan's Pricing Guide.
Board-Certified	Having special training in a certain area of medicine indicating by passing an advanced exam. Both primary care doctors and specialists may be board-certified.
Brand-Name Drug	A drug protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the drug by other companies without consent of the innovator, as long as the patent remains in effect.
Capitation	A method of payment in which a health plan receives a fixed amount for each person eligible to receive services ($s per member per month), whether or not the covered person becomes an active patient and without regard to the number and mix of services used by that patient – i.e., a negotiated per capita rate. The provider is responsible for delivering or arranging for the delivery of **all** health services required by the covered person under the conditions of the provider contract.
Card Program	The use of a drug benefit identification card which, when presented to a participating pharmacy, usually entitles the holder and/or their dependents to receive the medication for a co-payment.
Care Plan	A written plan for your healthcare. It tells what services you will get in order to reach and maintain your best physical, mental, and social well being.
Caregiver	Person who provides support and assistance with various activities to a family member, friend, or neighbor. May provide emotional or financial support, as well as hands-on help with different tasks.
Carrier	A private company that contracts with Medicare (to pay your Medicare Part B bills) or with Medicaid.
Case Management	A process whereby a patient's specific healthcare needs are identified and a plan is designed to efficiently utilize healthcare resources and to achieve the optimum patient outcome in the most cost-effective manner. A utilization management program that assists the patient in determining the most appropriate and cost-effective treatment plan.

Health Care Glossary

Term	Definition
Case Manager	An experienced professional (e.g., nurse, doctor or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.
Case Mix	A method by which a health care provider measures the service needs of the patient population, and may be based on age, medical diagnosis, severity of illness, or length of stay. A nursing home or hospital's actual case mix influences cost and scope of the services provided by the facility to the patient, and case mix reimbursement systems adjust payment rates accordingly.
Catastrophic Illness	A very serious and costly health problem that could be life threatening or cause life-long disability.
Categorically Needy	Under Medicaid, individuals who are aged, blind, or disabled or families and children who meet financial eligibility requirements for TANF (AFDC), Supplemental Security Income (SSI), or an optional state supplement.
Centers For Medicare & Medicaid Services (CMS)	The agency in the U.S. Department of Health and Human Services (HHS) that is responsible for administration of the Medicare and Medicaid programs. It was formerly known as the Health Care Financing Administration (HCFA**)**.
Certified (Certification)	Applies to healthcare providers, such as home health agencies, hospitals, nursing homes, dialysis facilities and others that successfully pass inspections by state government agencies. Medicare and Medicaid only pay for care provided by certified providers in a certified facility or program. Being certified is not the same as being accredited (**See Accredited, Accreditation)**.
Certified Nursing Assistant (CNA)	Nursing assistants who have met certain training, testing, and certification provisions and passed a competency examination that includes skills and theory components. CNA training programs must be approved by the Office of Long Term Care. The names of all Arkansas CNAs appear in the Long Term Care Facility Employment Clearance Registry. The registry also identifies CNAs for whom patient abuse or neglect or theft of patient property during the performance of their duties has been substantiated and individuals who have been disqualified from employment in long-term care facilities in Arkansas as a result of a criminal background check.
Chore Services	Help with chores such as home repairs, yard work, and heavy housecleaning.

Health Care Glossary

Term	Definition
Chronic Illness	Long-term or permanent illness (e.g., diabetes, arthritis) which often results in some type of disability and may require a person to seek help with various activities.
Claim	A claim is a request for payment for services and benefits you received. The term generally refers to the liability for healthcare services received by covered persons.
Claims Review	The method by which an enrollee's health care service claims are reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to be sure the cost of the service is not excessive.
Clinical Breast Exam	An exam by a doctor or healthcare provider to check for breast cancer by feeling and looking at your breasts. This exam is not the same as a mammogram and is usually done in the doctor's office along with a Pap test and pelvic exam.
Clinical Outcome	The status of the patient's health, especially after receipt of medical services. Assessment of outcomes may be dependent upon targeted goals, clinical markers, and the ability to provide objective measurements.
Clinical Practice Guidelines	Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.
Cognitive Impairment	Deterioration or loss of intellectual capacity which requires continual supervision to protect the insured or others that is evaluated by standardized tests to measure impairment in the area of (1) short or long-term memory, (2) orientation as to person, place and time, or (3) deductive or abstract reasoning. Such loss in intellectual capacity can result from Alzheimer's disease or similar forms of senility or dementia.
Co-insurance	The portion of covered healthcare costs for which the beneficiary has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.
Coinsurance (Outpatient Prospective Payment System)	Insurance that covers the portion of hospital and medical expenses that Medicare does not cover, after subtraction of any deductible. Medicare Part B Coinsurance usually reimburses 20% of the allowed amount.

Health Care Glossary

Term	Definition
Community Health Center	An ambulatory health care program usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs. These centers attempt to coordinate federal, state, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.
Community Mental Health Centers (CMHCs)	Nonprofit outpatient mental health facilities that contract with the Department of Health and Human Services (DHHS) to provide psychiatric care in their communities. They may also be authorized to provide partial hospitalization (PHP) services. Arkansas has 15 CMHCs that offer 24-hour emergency care and a full array of services including: diagnostic evaluation; treatment planning; individual or group therapy; medication management; case management; crisis services; vocational, housing and educational support; transportation; and rehabilitative and day treatment services.
Community-Based Services	Services designed to help older people and people with disabilities to remain independent and in their own homes. They can include senior centers, transportation, delivered or congregate meals, visiting nurses or home health aides, adult day care, and homemaker services.
Conditions of Participation (COP)	Standards a facility or supplier of services, desiring to participate in the Medicare or Medicaid program, is required to meet. These conditions include meeting a statutory definition of the particular institution or facility, conforming with state and local laws, and having an acceptable utilization review plan. Surveys to determine whether facilities meet conditions of participation are made by the appropriate state health agency.
Consolidated Omnibus Budget Reconciliation Act or 1985 (COBRA)	Legislation that requires most employers with group health plans to offer employees the opportunity to continue their group health care coverage under their employer's plan temporarily (up to 18 months) if their coverage otherwise would cease due to termination, layoff, or other change in employment status (referred to as "qualifying events").
Continuous Positive Airway Pressure Machine (CPAP)	A machine used to treat obstructive sleep apnea that delivers continuos air pressure for all breaths.

Health Care Glossary

Term	Definition
Continuum of Care	A range of clinical services provided to an individual or group, which may reflect treatment rendered during a single inpatient hospitalization, or care for multiple conditions over a lifetime. The continuum provides a basis for analyzing quality, cost, and utilization over the long term. Also, a comprehensive system of long-term care services and supports (including specialized health, rehabilitative, and residential services), in the community or in an institutional setting. The services focus on the social, residential, rehabilitative and supportive needs of individuals as well as needs that are essentially medical in nature.
Coordination Of Benefits	Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.
Co-pay/Co-payment	A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. Some co-payments are referred to as coinsurance, with the difference being that co-payments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered.
Cost	Actual expenses incurred by a facility for providing items or services to residents. For example, the cost of nursing home care includes direct costs (e.g., staff salary, facility, equipment supplies) and indirect costs (e.g., mortgage, general and administrative fees, and cost of capital).
Cost Containment	Control or reduction of inefficiencies in the consumption, allocation or production of healthcare services in order to lower healthcare costs. Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the cost of producing health services could be reduced by using a different combination of resources.
Cost Shifting	The redistribution of payment sources. Typically, cost shifting occurs when one payer obtains a discount on provider services, and the providers increase costs to another payer to make up the difference.
Coverage	The entire range of protection provided under an insurance contract.
Covered Benefit	A health service or item that is included in your health plan, and that is paid for either partially or fully.

Health Care Glossary

Term	Definition
Covered Services or Charges	Services or benefits for which Medicare or Medicaid will provide reimbursement. Under Medicaid, covered services consist of a combination of federally mandated services and optional services chosen by each state.
Creditable Coverage	Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period (**See Pre-existing Conditions**).
Custodial Care	Care that is not primarily skilled in nature. Generally considered to meet the personal needs of the patient (i.e., bathing, cooking, shopping etc.).
Customary Charge	The charge a physician or supplier usually bills his patients.
Customary, Prevailing, and Reasonable Charges	Method of reimbursement which limits payment to the lowest of the following: physician's actual charge, physician's median charge in a recent prior period (customary), or the 75th percentile of charges in the same time period (prevailing).
Deductible	The amount of eligible expense a covered person must pay each year from his/her own pocket before the plan will pay for eligible benefits.
Deficiency (Nursing Home)	A finding that a nursing home failed to meet one or more federal or state requirements.
Dehydration	A serious condition where your body's loss of fluid is more than your body's intake of fluid.
De-institutionalization	Policy which calls for the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.
Dementia	Term for a group of diseases (including Alzheimer's Disease) which are characterized by memory loss and other declines in mental functioning.
Denial of Payment	An enforcement sanction that can be used by a state agency or the federal government (CMS) when a nursing home has serious deficiencies. It can decertify the facility from Medicare and Medicaid, often simultaneously with action by the state to take away a facility's license to operate. As a lesser penalty, a state or the federal government may deny payment only for new admissions, but continue to make payments for current residents.

Health Care Glossary

Term	Definition
Dental Services	Under the Nursing Home Reform Law (1987), each facility must provide, directly or under agreements, routine and emergency dental services to meet the needs of each resident.
Department of Health & Human Services (HHS)	The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves, including Medicare (health insurance for elderly and disabled Americans) and Medicaid (health insurance for low-income people). Key divisions or agencies include: the Centers for Medicare and Medicaid Services (CMS); the National Institute of Health (NIH); the Centers for Disease Control and Prevention (CDC); the Food and Drug Administration (FDA); the Administration on Aging (AoA); the Office of the Inspector General (OIG), etc. HHS works closely with OIG, other law enforcement agencies and CMS to investigate and enforce the laws to protect beneficiaries and taxpayers. HHS helps providers to file Medicare claims correctly and monitors claims payments to stem fraud, waste and abuse.
Department of Justice (DOJ)	The U.S. Department of Justice was established in June 1870 (28 U.S.C. 501, 503), with the Attorney General as its head. It has 39 separate components, including the U.S. Attorneys who prosecute offenders and represent the U.S. Government in court; the Federal Bureau of Investigation (FBI), which is the principal investigative arm of the DOJ, with authority and responsibility to investigate all fraud committed against the U.S. government; and the Office of the Inspector General (OIG), which is responsible for investigating suspected fraud and abuse and performing audits and inspections of HHS programs.
Developmental Disability (DD)	A disability that originates before age 18, can be expected to continue indefinitely, and constitutes a substantial handicap to the disabled person's ability to function normally.
Diabetic Durable Medical Equipment	Purchased or rented ambulatory items, such a glucose meters and insulin infusion pumps, prescribed by a health care provider for use in managing a patient's diabetes, that are covered by Medicare.
Diagnosis	The name for the health problem that you have.

Health Care Glossary

Term	Definition
Diagnosis-Related Groups (DRGs)	A classification system which uses diagnosis information to establish hospital payments under Medicare. This system groups patient needs into 467 categories, based upon the coding system of the International Classification of Disease, Ninth Revision-Clinical Modification (ICD-9-CM). A way to pay hospitals for health care based on diagnosis, age, gender, and complications. Patients are assigned to groups with similar diagnoses that are expected to require similar levels of resource consumption. A DRG determines how much the federal government will pay a hospital for treating a Medicare patient under the Prospective Payment System (PPS) established in 1983. Under this system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual. Patients are grouped according to diagnosis, type of treatment, age, sex and other relevant criteria. The system allows for "outliers" whose special circumstances require higher reimbursement rates.
Diagnostic and Statistical Manual of Mental Disorders (DSM)	A tool used by the medical and psychological communities to identify and classify behavioral, cognitive, and emotional problems according to a standard numerical coding system of mental disorders.
Disability	Any condition that results in functional limitations that interfere with an individual's ability to perform his/her customary work and which results in substantial limitation in one of more major life activities. Also, condition(s) that prevent or limit an individual's ability to engage in normal activities. These may be temporary. There are varying types (functional, occupational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Benefits are often available only for specific disabilities, such as total and permanent (the requirement for Social Security and Medicare).
Disallowance	A denial by the payer for portions of the claimed amount. Examples of possible disallows include coordination of benefits, not-covered benefits, or amounts over the maximum fee.
Discharge Planning	A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.
Disease	A disorder with specific cause and recognizable signs and symptoms; any bodily abnormality leading to interruption, cessation, or disorder of proper physical or mental functions, systems, or organs, except those resulting directly from physical injury.

Health Care Glossary

Term	Definition
Disease Management	An effort to improve patient outcomes and lower costs by organizing managed care initiatives around patients with a particular disease or condition.
Dispense As Written (DAW)	A prescribing directive issued by physicians to indicate that the pharmacy should not in any way alter a prescription. Such alterations are usually done in order to substitute a generic drug for the brand-name drug ordered.
Dispensing, Fill or Professional Fee	The amount paid to a pharmacy for each prescription, in addition to the negotiated formula for reimbursing ingredient cost.
Do Not Resuscitate Order (DNR)	A code or order usually appearing in a patient's medical record indicating that, in the event the heart and/or breathing stops, no intervention should be undertaken by the staff. This does not mean that the patient does not receive care. Continuing care is provided as it would be to any individual (medications for pain, antibiotics, Heimlich Maneuver, etc.) except as stated above.
Drug Detailing	Presenting information about a brand-name drug product to prescribers to educate them about its activity, uses, side effects, proper dosage and administration, etc.
Drug Formulary	A list of prescription drugs that are preferred for use by a health plan and which may be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan.
Drug Utilization Review (DUR)	A quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy. Most often focuses on over utilization.
Dual Eligibles	Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.
Dually Certified Facility	A facility certified for both Medicare and Medicaid.
Durable Medical Equipment (DME)	Medically necessary equipment that is ordered by a doctor, can withstand repeated use, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. These items (such as walkers, wheelchairs, or hospital beds) are paid for under Medicare Part B and Part A for home health services.

Health Care Glossary

Term	Definition
Durable Medical Equipment Regional Carrier (DMERC)	A private company that contracts with Medicare to pay bills for durable medical equipment.
Durable Power of Attorney (DPA)	A written designation by a capable person (principal) to grant to another person (agent) authority to act on his or her behalf if incapacity occurs. A DPA allows the principal to control who may act and what actions may be taken. DPAs may affect both property and health care decision-making. The DPA for health care is an important option since it allows the agent to make everyday health care decisions, in addition to those relating to terminal illness or persistent vegetative state. Arkansas has a Durable Power of Attorney for Health Care (Ark Code Ann. § 20-13-104).
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally mandated part of the Medicaid program. The law requires that all states have in effect a program for eligible children under age 21 to test for physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The state programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening and, if necessary, to assist in obtaining appropriate treatment.
Eligible Expenses	Reasonable and customary charges or the agreed upon health services fee for services and supplies covered under a health plan.
Emergency	A serious medical condition resulting from injury, sickness or medical illness which arises suddenly and requires immediate care and treatment, generally within 24 hours of onset, to avoid jeopardy to a person's life or health.
Emergency Medical Services (EMS)	Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.
End-Stage Renal Disease (ESRD)*	Kidney failure that is severe enough to need lifetime dialysis or a kidney transplant.
Enrollee	An individual who is covered under a health plan contract and who is eligible on his/her own behalf (not by virtue of being an eligible dependent) to receive the health services provided under the contract.
Episode Of Care	The health care services given during a certain period of time, usually during a single hospital stay.

Health Care Glossary

Term	Definition
Escort Services	Provides transportation for older adults to services and appointments. May use bus, taxi, volunteer drivers, or van services that can accommodate wheelchairs and persons with other special needs.
Estate Recovery	By law states are required to recover funds from certain deceased Medicaid recipients' estates up to the amount spent by the state for all Medicaid services (e.g., nursing facility, home and community-based services, hospital, and prescription costs).
Ethics Committee	Consulting committee in a hospital or other institution whose role is to analyze ethical dilemmas and to advise and educate health care providers, patients, and families regarding difficult treatment decisions.
Exclusions (Medicare)	Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.
Expenditures	Under Medicaid, “expenditures” refers to an amount paid out by a state agency for the covered medical expenses of eligible participants.
Explanation Of Benefits (EOB)	The statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.
Explanation of Medicare Benefits (EOMB)	A notice that is sent to you after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. This is being replaced by the Medicare Summary Notice (MSN), which sums up all the services (Part A and B) that were given over a certain period of time, generally monthly (**See Medicare Summary Notice, Medicare Benefits Notice**).
Extended Care	Long-term care, ranging from routine assistance for daily activities to sophisticated medical and nursing care for those needing it. The care, covered under certain insurance policies, can be provided in homes, day-care centers or other facilities.

Health Care Glossary

Term	Definition
False Claims Act	A law that is designed to reward any person who knows that an individual or company has financially defrauded the federal government by allowing that whistleblower to file a "qui tam" lawsuit to recover damages on the government's behalf. Liable defendants in qui tam cases must pay the government for its losses and pay penalties for fraud. A whistleblower who brings a successful qui tam case under the False Claims Act is entitled to a reward, which is based on the amount of money the government recovers. The False Claims Act also benefits whistleblowers by ensuring them some job protection. Some of the types of fraud against the government that can be the basis of a qui tam lawsuit include Medicare fraud, Medicaid fraud, defense contractor fraud, customs fraud, bid-rigging on government projects, environmental fraud and research fraud. "Qui tam" is short for the Latin phrase – "qui tam pro domino rege quam pro se ipso in hac parte sequitur" – which translates as "he who brings an action for the king as well as for himself." **(See qui tam lawsuit)**
Favorable Selection	A tendency for utilization of health services in a population group to be lower than expected or estimated.
Federal Bureau of Investigation (FBI)	The principal investigative arm of the U.S. Department of Justice (DOJ), with authority and responsibility to investigate all fraud committed against the U.S. government. The FBI's authority to investigate health care fraud extends beyond specified federal programs such as Medicare and Medicaid to include all victims of the crime, whether government programs or private insurance companies, business entities or individuals. The FBI also is authorized to provide other law enforcement agencies with cooperative services, such as fingerprint identification, laboratory examinations, and police training. However, the FBI does not give an opinion or decide if an individual will be prosecuted. The federal prosecutors employed by the DOJ or the U.S. Attorneys offices are responsible for making this decision and for conducting the prosecution of the case. The FBI has also become increasingly involved in the investigation of Qui Tams, or civil false claim lawsuits, filed under seal by individuals who allege fraud against the United States. The successful investigation of these cases, by the FBI and other agencies, has returned hundreds of millions of dollars to the Medicare Trust Fund.
Federal Supply Schedule (FSS)	The government's purchasing list for all products that the government uses ranging from toothpaste to construction equipment. In 1992 Congress gave the Department of Veterans Affairs statutory authority to manage the purchasing of pharmaceuticals and biologicals through the FSS.

Health Care Glossary

Term	Definition
Federally Qualified Health Centers (FQHCs)	Public or not-for-profit, consumer-directed health care corporations which provide high quality, cost-effective and comprehensive primary and preventive care to medically underserved and uninsured people. This nationwide network of safety-net providers is primarily comprised of health centers which are supported by federal grants under the US Public Health Service Act (PHSA). These providers must meet rigorous federal standards related to quality of care and services as well as cost, and they are qualified to receive cost-based reimbursement under Medicaid and Medicare law. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.
Fee-for-Service Reimbursement	The way traditional Medicare and health insurance work. Medical providers bill for whatever service they provide. Medicare and/or traditional insurance pay their share, and the patient pays the balance through co-payments and deductibles.
Fee Schedule	A listing of codes and related services with pre-established payment amounts which could be percentages of billed charges, flat rates or maximum allowable amounts.
Fiscal Agent	A contractor who processes or pays vendor claims on behalf of CMS. Under Medicare, fiscal agents are called intermediaries (for Hospital insurance) and carriers (for supplementary medical insurance).
Fiscal Intermediary	An organization that contracts with the federal government to process Medicare or Medicaid claims.
Formulary	A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.
Fraud	Obtaining or attempting to obtain services or payments by dishonest means, with intent, knowledge and willingness. To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.
Gatekeeper	A primary healthcare practitioner: (1) who provides primary care services to an enrollee; (2) who is generally responsible for coordinating the enrollee's healthcare; and (3) with whom, other than in an emergency, a patient must consult to obtain a referral to a specialist provider. Gatekeepers are sometimes called care coordinators.

Health Care Glossary

Term	Definition
Generic Drug	A chemically equivalent copy of a brand-name drug whose patent has expired. Drug formulations must be of identical composition with respect to the active ingredient (i.e., meet official standards of identity, purity, and quality of active ingredient). A generic is typically less expensive and sold under a common or "generic" name for that drug. Also called the generic equivalent.
Generic Substitution	Dispensing a generic drug in place of a brand-name medication.
Handicapped	As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.
Health Care Financing Administration (HCFA)	Former name of the government agency now called the Centers for Medicare & Medicaid Services (CMS).
Health Care Provider	A person who is trained and licensed to give health care. Also, a place licensed to give health care. Doctors, nurses, hospitals, skilled nursing facilities, some assisted living facilities, and certain kinds of home health agencies are examples of health care providers.
Health Insurance Portability and Accountability Act (HIPAA)	Federal health insurance legislation passed in 1996, also called the "Kassebaum-Kennedy" law, which sets standards for access, portability, and renewability of group and individual health care coverage. HIPAA allows, under specified conditions, for long-term care insurance policies to be qualified for certain tax benefits under Section 7702(b) of the Internal Revenue Code. This law expands your healthcare coverage if you have lost your job. If you move from one job to another, HIPAA protects you and your family if you have pre-existing medical conditions and/or problems getting health coverage. HIPAA also: limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage; usually gives you credit for health coverage you have had in the past; may give you special help with group health coverage when you lose coverage or have a new dependent; and generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

Health Care Glossary

Term	Definition
Home- and Community-Based Waivers	Section 2176 of the Omnibus Reconciliation Act permits states to offer, under a waiver, a wide array of home- and community-based services that an individual may need to avoid institutionalization. Services which may be offered under the waiver program include case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and others.
Home Health Agency (HHA)	A public or private organization that provides home health services (e.g., skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides) supervised by a licensed health professional in the patient's home either directly or through arrangements with other organizations.
Home Health Aide	A person who, under the supervision of a home health or social service agency, assists elderly, ill or disabled person with household chores, bathing, personal care, and other daily living needs. Social service agency personnel are sometimes called “personal care aides.”
Home Health Care	Medical, social, and supportive services provided in the home to help the recipient to maintain independent functioning and avoid institutionalization. Includes skilled nursing care and a wide range of health-related services such as assistance with medications, wound care, intravenous (IV) therapy, and help with basic needs such as bathing, dressing, mobility, etc.
Home Health Care Services	Services and items furnished to an individual by a home health agency, or by others under arrangements made by such an agency, furnished under a plan established and periodically reviewed by a physician and supervised by a licensed nurse. The services are provided on a visiting basis in an individual's home and may include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy, medical social services; medical supplies and appliances (other than drugs and biologicals); and personal care services.
Homebound	Normally unable to leave home. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services. A need for adult day care does not keep you from getting home health care for other medical conditions.
Homemaker or Home Health Aide	A person who is paid to help in the home with personal care, light housekeeping, meal preparation, and shopping. Some states and agencies make a distinction between homemaking (or housekeeping) services and personal care services.

Health Care Glossary

Term	Definition
Homemaker Services	Household services, such as shopping, cooking and cleaning, that may be part of a home care program. These services can be delivered in conjunction with home health care, as a separate service to those with functional limitations but who are otherwise healthy, or to forestall the need for institutional care.
Hospice	A facility or program engaged in providing palliative and supportive care of the terminally ill and their families, either directly or on a consulting basis with the patient's physician or another community agency. The whole family is considered the unit of care, and care extends through their period of mourning.
Hospice Care	Care that addresses the physical, spiritual, emotional, psychological, social, financial, and legal needs of the dying patient and his/her family in a coordinated continuum of home, outpatient, and home-like inpatient care. It employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. The care shall be available 24 hours a day, 7 days a week, and provided on the basis of need, regardless of ability to pay. Hospice care is covered under Medicare Part A (Hospital Insurance).
Hospital Insurance (Part A)	The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
Hydration	The level of fluid in the body. The loss of fluid, or dehydration, occurs when you lose more water or fluid than you take in. Your body cannot keep adequate blood pressure, get enough oxygen and nutrients to the cells, or get rid of wastes if it has too little fluid.
Impairment	Any loss or abnormality of psychological, physiological, or anatomical function.
Indigent Care	Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for federal or state programs, the costs covered by Medicaid are generally recorded separately from indigent care costs.
Indirect Cost	Cost that cannot be identified directly with a particular activity, service or product of the program experiencing the cost. Indirect costs are usually apportioned among the program's services in proportion to each service's share of direct costs.

Health Care Glossary

Term	Definition
Informed Consent	A legal term that refers to a person's consent to a proposed medical intervention after receiving relevant information. The information that is legally required includes: diagnosis, nature and purpose of proposed intervention, risks and consequences of proposed treatment, probability that the treatment will be successful, feasible treatment alternatives, and prognosis if the treatment is not given.
Inpatient	An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician (customarily for at least 24 hours).
Inpatient Care	Health care that you get when you are admitted to a hospital.
Intermediate Care Facility for the Mentally Retarded (ICF-MR)	ICF-MR 16 beds or more - a public or privately operated facility with 16 or more beds that provides diagnosis, active treatment and rehabilitation of persons with mental retardation or persons with related conditions in a protective residential setting. ICF-MR 15 beds or less - a facility with between four and 15 beds that provides diagnosis, active treatment and rehabilitation of persons with mental retardation or persons with related conditions in a protective residential setting.
Independent Physiological Laboratory (IPL)	A free standing facility (not part of a doctor's office or other health care facility) that performs non-invasive diagnostic tests, such as x-rays, magnetic resonance imaging (MRI), oxygen tests (pulse oximetry), etc.
Legend Drug	A drug that, by law, can be obtained only by prescription and bears the label, “Caution: federal law prohibits dispensing without a prescription **(See Prescription Medication)**.
Level of Care (LOC)	Amount of assistance required by consumers that may determine their eligibility for programs and services. The levels are protective, intermediate, and skilled.
Liability Insurance	Liability insurance is insurance that protects against claims based on negligence or inappropriate action or inaction that results in bodily injury or damage to property.
Licensed (Licensure)	This means a long-term care facility has met certain standards set by a State or local government agency.
Life Care Facility	A facility that provides "life care" or continuing care as defined in Arkansas Code 23-93-103(2). No additional charges are made for nursing care or personal care beyond those charged all residents of the facility who are not receiving nursing care or personal care services.

Health Care Glossary

Term	Definition
Lifetime Maximum Benefit	A limitation on financial coverage for health care for an individual stated by an insurer. This amount serves as a cap on contractual liability and can be exceeded only in rare and unusual circumstances.
Lifetime Reserve Days (Medicare)	Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($406 in 2002).
Limiting Charge	The most money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment **(See Approved Amount, Assignment).**
Long-Term Care	Non-acute care provided over a 24 hour period for 25 or more consecutive days. It involves providing a set of healthcare, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, or disabled) in an institution or at home on a long-term basis. Most long-term care is custodial care. Medicare does not pay for this type of care.
Long-Term Care Facility	A nursing home, residential care facility (RCF), post-acute head injury retraining and residential care facility, adult daycare facility, or any other facility that provides long-term medical or personal care.
Long-Term Care Insurance	A private insurance policy to help pay for some long-term medical and non-medical or custodial care, like help with activities of daily living (ADLs). Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies."
Magnetic Resonance Imaging (MRI)	A noninvasive diagnostic imaging technique used to visualize soft tissues.
Malnutrition	A health problem caused by the lack of necessary nutrients.
Mammogram	A special x-ray of the breasts. Medicare covers the cost of a mammogram once every 12 months for women over 40 who are enrolled in Medicare.

Health Care Glossary

Term	Definition
Managed Care	A system of healthcare delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to high quality, cost-effective healthcare. Generally, managed care implies that there is some form of influence in the delivery of health care by persons other than the caregiver and patient. It includes several concepts as part of its program: quality assurance, aggressive care management, peer review, and data gathering and dissemination to providers. The gatekeeper - one person, usually a primary care physician - opens the door to the varied disciplines, providing the necessary, coordinated care.
Mandated Benefits	Those benefits which health plans are required by state or federal law to provide to policyholders and eligible dependents.
Maximum Allowable Cost (MAC)	The reimbursement limit established by individual states for multiple source medications dispensed under the Medicaid program.
Maximum Out-of-Pocket Costs	The limit on total member co-payments, deductibles and coinsurance under a benefit contract.
Medicaid	A joint federal and state program, authorized by Title XIX of the Social Security Act, to provide medical care for certain categories of low-income individuals. These categories include families with dependent children and persons who are either 65 years of age and older, legally blind or permanently and totally disabled. Federal regulations specify mandated services, but states can specify services and eligibility standards. The federal government's share of costs ranges from 50-78% and is based on per capita income in the state. In Arkansas, the current federal share is 75%. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
Medicaid Buy-In	A provision in certain health reform proposals whereby the uninsured would be allowed to purchase Medicaid coverage by paying premiums on a sliding scale based on income.

Health Care Glossary

Term	Definition
Medicaid Fraud Control Units (MFCUs)	Federally funded state law enforcement entities that investigate and prosecute Medicaid provider fraud and violations of state laws pertaining to fraud in the administration of the Medicaid program. They also review complaints of patient abuse and neglect and of misappropriation of patient funds in all residential healthcare facilities that receive Medicaid funds and, if appropriate, investigate and prosecute the people responsible. MFCUs are staffed by attorneys, investigators and auditors trained in the complex litigation aspects of healthcare fraud and patient abuse and neglect. They are required to be separate and distinct from the state Medicaid program and are usually located in the state attorney general's office. The authority to protect nursing home residents derives from the Adult Abuse Act of the Arkansas Criminal Code, which forbids abuse, neglect and/or exploitation of the elderly.
Medical Care	Services that are performed under the direction of a physician on behalf of patients by physicians, nurses and other professional and technical personnel.
Medical Insurance (Part B)	The part of Medicare that covers doctors' services; outpatient surgery; durable medical equipment (DME); outpatient lab tests; and physical, speech and occupational therapy **[See Medicare Part B (Medical Insurance]**.
Medical Record	Clinical documentation of a patient's health care, including, but not necessarily limited to, the medical, nursing, social and rehabilitative care provided to the patient.
Medically Necessary	Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of that condition; meet the standards of good medical practice in the local area; are not considered experimental; and are not mainly for the convenience of you or your doctor. They also cannot be omitted without adversely affecting the individual's condition or the quality of medical care.
Medicare	The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Health Care Glossary

Term	Definition
Medicare Benefits Notice (MBN)	A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) for Part B services or a Medicare Summary Notice (MSN) (**See Explanation of Medicare Benefits, Medicare Summary Notice**).
Medicare Carrier	A private company that contracts with Medicare to pay Part B bills.
Medicare Coverage	Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).
Medicare Hospital Insurance	This is Part A of Medicare. It helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care.
Medicare Integrity Program (MIP)	A program established by the Health Insurance Portability and Accountability Act (HIPAA; also known as the Kassebaum-Kennedy legislation) that gives the Centers for Medicare and Medicaid Services (CMS) specific authority to enter into contracts with entities to promote the integrity of the Medicare program.
Medicare Medical Insurance	This is Part B of Medicare. It helps pay for medically necessary doctor services and many other medical services and supplies.
Medicare Part A (Hospital Insurance)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
Medicare Part B (Medical Insurance)	Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.
Medicare Private Fee-For-Service Plan	A private insurance plan that accepts people with Medicare. The insurance plan, rather than the Medicare program, decides how much it will pay and what you will pay for the services you get. You may pay more for Medicare-covered benefits or you may have extra benefits not covered by the Original Medicare Plan.
Medicare Summary Notice (MSN)	A notice that is sent to a Medicare beneficiary after a claim is processed, explaining what the provider billed for, how much was approved, how much Medicare paid and what the beneficiary must pay. This has replaced the Explanation of Medicare Benefits (EOMB), which summarizes all services over a specified period, generally monthly.

Health Care Glossary

Term	Definition
Medicare Supplement Insurance	Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage.
Medicare-Approved Amount	The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier.
Medigap Insurance	Health insurance policy sold by a private insurance company that is specifically designed to help pay health care expenses either not covered or not fully covered by Medicare. Also called Medicare supplement insurance.
Mental Health Services	A variety of services provided to people of all ages, including counseling, psychotherapy, psychiatric services, crisis intervention, and support groups. Issues addressed include depression, grief, anxiety, stress, and severe mental illnesses.
Mental Illness/Impairment	A deficiency in the ability to think, perceive, reason, or remember, resulting in loss of the ability to take care of one's daily living needs.
Modified Fee-for-Service	A system where providers are paid on a fee-for-service basis, with certain fee maximums for each procedure.
Morbidity	The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.
Mortality	Death. Used to describe the relation of deaths to the population in which they occur.
National Committee For Quality Assurance (NCQA)	A non-profit organization that accredits and measures the quality of care in Medicare health plans.
National Median Charge	The national median charge is the exact middle amount of the amounts charged for the same service. This means that half of the hospitals and community mental health centers charged more than this amount and the other half charged less than this amount for the same service.

Health Care Glossary

Term	Definition
Nonparticipating Physician	A doctor or supplier who does not accept assignment on all Medicare claims **(See Assignment)**.
Notice Of Medicare Premium Payment Due – HCFA 500	The billing notice sent to Medicare beneficiaries who must pay their Medicare premium directly. Notices are sent either monthly or quarterly.
Notice of Non-Coverage	A written explanation of why you are being discharged from a hospital. According to federal law, your discharge date must be determined solely by your medical needs, not by Diagnosis Related Groups (DRGs) or Medicare payments. The notice will state either that your doctor or a peer review organization agrees with the hospital's decision that Medicare will no longer pay for your hospital care.
Nurse Practitioner (NP)	A registered nurse (RN) who has 2 or more years of advanced training, has passed a special exam, and works in an expanded nursing role, usually with a focus on meeting primary health care needs. NPs conduct physical examinations, interpret laboratory results, select plans of treatment, identify medication requirements, and perform certain medical management activities for selected health conditions. Some NPs specialize in geriatric care.
Nursing Home	An institution, or other place for the reception, accommodation, board, care, or treatment of more than three unrelated individuals, who, because of physical or mental infirmity are unable to sufficiently or properly care for themselves, and for which reception, accommodation, board, care, and treatment, a charge is made. The term "Nursing Home" shall not include the offices of private physicians and surgeons, boarding homes, or hospitals, or institutions operated by the Federal Government.
Nutrition	Getting enough of the right foods with vitamins and minerals a body needs to stay healthy. Malnutrition, or the lack of proper nutrition, can be a serious problem for older people.
Obstructive Sleep Apnea (OSA)	Recurrent episodes during sleep when closure of the throat due to muscle relaxation prevents passage of air into the lungs for 10 seconds or more. Obstructive apnea episodes can last as long as 2 minutes and are almost always associated with a reduction in the oxygen level in the blood. As long as sleep continues, the apnea continues. It is only terminated and the victim's life is saved by waking up.
Occupancy Rate	A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a facility's beds occupied.

Health Care Glossary

Term	Definition
Occupational Therapy (OT)	Services designed to help patients improve their independence with activities of daily living (such as bathing, preparing meals, housekeeping) through rehabilitation, exercises, and the use of assistive devices. May be covered in part by Medicare.
Office of the Inspector General (OIG)	The agency within the U.S. Department of Health and Human Services (HHS) responsible for investigating suspected fraud and abuse and performing audits and inspections of HHS programs. The OIG has authority to levy certain sanctions and civil money penalties. The OIG maintains an anti-fraud hotline to report alleged fraud and abuse in the Medicare and Medicaid programs. The hotline, 1-800-HHS-TIPS (1-800-447-8477), provides assistance to callers in English, Spanish and Chinese. Tips involving possible errors in beneficiaries' Medicare statements are generally referred to the claims-processing contractors for further review, while suspected fraud is referred to appropriate law enforcement agencies for investigation.
Office of Long Term Care (OLTC)	The Arkansas regulatory agency within the Department of Health and Human Services (DHHS) that conducts investigations of complaints in which abuse or neglect of residents of long-term care facilities, or misappropriation of resident property, is witnessed, suspected, or alleged. Complainant information is kept confidential. If violations of laws or regulations are found, the OLTC can impose fines or other sanctions against the facility, and can exclude the perpetrator from employment in long-term care facilities. Any person can make a complaint, and may do so anonymously. In addition, complaints can be made by mail or email. The OLTC also conducts periodic, unannounced surveys of all long-term care facilities in Arkansas to ensure that they adhere to minimum requirements for both resident care and physical conditions. The OLTC can impose fines, revoke licenses, or take other action to ensure compliance. To report suspected incidents of neglect or abuse of a resident of a long-term care facility, call Toll-free 1-800-582-4887.
Older Americans Act (OAA)	Federal legislation that specifically addresses the needs of older adults in the United States. Provides some funding for aging services (such as home-delivered meals, congregate meals, senior centers, employment programs). Creates the structure of federal, state, and local agencies that oversee aging services programs.

Health Care Glossary

Term	Definition
Ombudsman or Long-Term Care Ombudsman	A person who advocates for residents of nursing homes and residential care facilities and receives, investigates and resolves complaints on behalf of nursing home residents and their families. An ombudsman regularly visits residents to hear their concerns and complaints and seeks to improve the quality of life of residents of long-term care facilities. Arkansas Ombudsmen receive 40 hours of classroom instruction, serve as interns for 20 hours and pass a certification examination. They are hired, housed, and supervised by the eight Area Agencies on Aging (AAAs). The nine local ombudsmen visit every nursing home and RCF in Arkansas at least once in every quarter. In the absence of any enforcement or regulatory power of their own, they provide information about ongoing problems to state surveyors at the Office of Long Term Care (OLTC).
Operation Restore Trust (ORT)	A joint project of the Administration on Aging (AoA), the Centers for Medicare and Medicaid Services (CMS), and the Office of the Inspector General (OIG) designed to fight error, fraud, and abuse in the Medicare and Medicaid programs. During its demonstration phase (beginning in 1995 in five states), ORT returned $23 for every $1 spent. Other critical partners in this effort include AoA's grantees, healthcare providers, senior volunteers, beneficiaries and their families, the U.S. Department of Justice (DOJ), state Medicaid agencies, Medicare contractors, and Area Agencies on Aging (AAAs). AoA focused its initial anti-fraud and abuse efforts on training state and local ombudsmen and volunteers to recognize and report suspected cases of fraud and abuse in nursing homes. It later expanded these efforts by providing training to other aging network personnel, including staff and volunteers of AAAs, health insurance counselors, and other service providers.
Original Medicare Plan	A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (hospital insurance) and Part B (medical insurance).
Out-Of-Pocket Costs or Expenses (OOPs)	The portion of payments for health services required to be paid by the enrollee, including co-payments, coinsurance and deductibles.
Outcome Measures	Assessments used to gauge the results of treatment for a particular disease or condition. They include such parameters as: the patient's perception of restoration of function; quality of life and functional status; and objective measures of mortality, morbidity and health status.

Health Care Glossary

Term	Definition
Outcomes Management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement – often in a formal program of continuous quality improvement.
Outpatient Care	Medical or surgical care that does not include an overnight hospital stay.
Outpatient Hospital Services (Medicare)	Medical or surgical care paid for (all or in part) by Medicare Part B, including: blood transfusions; certain drugs; hospital billed laboratory tests; mental health care; medical supplies; care in an emergency room, outpatient clinic or same day surgery facility; and x-rays and other radiation services.
Outpatient Prospective Payment System	The way that Medicare will pay for most outpatient services at hospitals or community mental health centers under Medicare Part B.
Outpatient Services	Medical and other services provided on a non-resident basis (patients are not admitted to the facility) by a hospital or other qualified facility, such as a mental health clinic, rural health clinic, mobile x-ray unit, or freestanding dialysis unit.
Over-the-Counter (OTC) Drug	A drug product that does not require a prescription under federal or state law.
Oximetry	Pulse oximetry is a simple non-invasive method of monitoring the percentage of hemoglobin (Hb) that is saturated with oxygen.
Pap Test	A test to check for cancer of the cervix, the opening to a woman's uterus.
Part A (Medicare)	Medicare hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care **(See Hospital Insurance)**.
Part B (Medicare)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment (DME), and some medical services that are not covered by Part A **(See Medical Insurance)**.
Partial Hospitalization Programs (PHPs)	Programs designed to keep patients with severe mental conditions from becoming hospitalized by providing intensive psychotherapy in a structured day outpatient setting.
Participating Physician Or Supplier	A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts **(See Assignment)**.

Health Care Glossary

Term	Definition
Pre-admission Screening and Resident Review program (PASARR)	The federally mandated program to determine medical necessity for nursing facility placement and need for specialized services. All persons suspected of having mental illness, mental retardation or related condition must be screened prior to admission to a nursing facility.
Patient Advocate	A person whose job is to speak on a patient's behalf and help patients get any information or services they need.
Peer Review Organization (PRO)	A professional medical organization (consisting of physicians and other health professionals) that enters into an agreement with the U.S. Department of Health and Human Services (HHS) to assume the responsibility for the review of the quality and appropriateness of services covered by Medicare, Medicaid, and the Maternal and Child Health Program. PROs determine whether services are medically necessary, provided in accordance with professional standards and, in the case of institutional services, rendered in the appropriate setting. In Arkansas, the PRO is Arkansas Foundation for Medical Care (AFMC), a nonprofit corporation dedicated to the clinical evaluation and improvement of health care in Arkansas. AFMC provides in-depth quality evaluation and improvement programs for Medicare, Medicaid and other payors; offers a variety of data management services to both the public and private sectors; and conducts extensive patient and public health education activities. Formerly known as “Quality Improvement Organizations” (QIOs).
Pelvic Exam	An exam to check if internal female organs are normal by feeling their shape and size.
Periods Of Care (Hospice)	A set period of time that you can get hospice care after your doctor says that you are eligible and need hospice care.
Permit of Approval (POA)	Corresponds to the Certificate of Need (CON) in other states. A permit is issued by the Health Services Permit Commission to an individual, organization or health care provider who is proposing to construct, modify, or expand a facility, or to offer new or different types of health services.

Health Care Glossary

Term	Definition
Personal Care	Non-medical services including assistance with activities of daily living, personal hygiene and grooming, preparation of meals, some household services, self-administration of medications, and preparing special diets – tasks pertaining to a person's functional abilities which enable the person to be treated on an outpatient basis rather than on an inpatient basis. A monthly benefit limit applies for all recipients, regardless of age. Medicaid covers personal care services in a recipient's home. A physician must approve the personal care service plan.
Pharmacy And Therapeutics (P&T) Committee	An organized panel of physicians and pharmacists from varying practice specialties, who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. A major function of such a committee is to develop, manage and administer a drug formulary.
Physical Therapy (PT)	Treatment designed to restore/improve movement and strength in people whose mobility has been impaired by injury and disease. May include exercise, massage, heat, light, water therapy, and assistive devices. May be covered in part by Medicare.
Physician Assistant (PA)	A person who has 2 or more years of advanced training, has passed a special exam, is licensed or otherwise credentialed, and performs tasks that might otherwise be performed by a physician under the direction of a supervising physician.
Physician Services	Services provided by an individual licensed under state law to practice medicine or osteopathy.
Planning and Service Area (PSA)	A geographic area served by an Area Agency on Aging.
Plan Of Care	Your doctor's written plan saying what kind of services and care you need for your health problem.
Podiatrist	A physician specializing in the diagnosis and treatment of diseases, defects and injuries of the foot.
Pre-Admission Certification	A process under which admission to a healthcare facility is reviewed in advance to determine need and appropriateness and to authorize a length of stay consistent with norms for the evaluation.
Pre-existing Condition (PEC)	Any medical condition that has been diagnosed or treated within a specified period immediately preceding the effective date of coverage of a healthcare plan.

Health Care Glossary

Term	Definition
Premium	The periodic payment (e.g., monthly, quarterly) to Medicare, an insurance company, or a health care plan that is required to keep an insurance policy in force.
Prescription Medication	A drug approved by the Food and Drug Administration (FDA) which can, under federal and state law, be dispensed only pursuant to a prescription order from a duly licensed prescriber, usually a physician.
Preventive Care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine physical examinations, immunizations and well-person care. Preventive medicine is also concerned with general prevention measures aimed at improving the healthfulness of the environment.
Primary Care	Basic or general health care traditionally provided by family practice, pediatrics and internal medicine. A nurse practitioner (NP) can also provide this basic level of health care.
Primary Care Physician (PCP)	A doctor who is trained to give you basic care and who determines whether you need to see a specialist or require other non-routine services. Your primary care doctor is the doctor you see first for most health problems. In many Medicare managed care plans, you must see your primary care doctor before you see any other healthcare provider.
Primary Payer	An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or another health insurance plan.
Prior Authorization	The process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.
Private Contract	A contract between you and a doctor who has decided not to offer services through the Medicare program. This doctor cannot bill Medicare for any services or supplies given to you and other Medicare patients for at least 2 years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.
Procedure	Something done to fix a health problem or to learn more about it (for example, surgery, tests, and putting in an intravenous line).
Provider	A physician, hospital, group practice, nurse, nursing home, pharmacy or any individual or group of individuals that provides a health care service.

Health Care Glossary

Term	Definition
Psychiatric Inpatient Hospital	The Arkansas State Hospital (ASH) is licensed by the Arkansas Department of Health (ADH) and the Centers for Medicare and Medicaid Services (CMS), and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The hospital includes 90 beds for acute psychiatric admission; a 60-bed forensic treatment services program which offers assistance to circuit courts throughout the state; a 16-bed adolescent treatment program for youth age 13-18; and a program for juvenile sex offenders. Prior to the development of the sex offenders program, all such individuals were sent to out-of-state treatment facilities. This program became operational in January 1995.
Psychiatric Residential Treatment Facility (PRTF)	A facility that provides 24-hour psychiatric residential treatment (other than a psychiatric inpatient hospital) in a structured, systematic therapeutic program of treatment supervised by a psychiatrist, for emotionally disturbed children and/or adolescents 6-21 years of age, grouped in an age appropriate manner.
Qualified Medicare Beneficiary (QMB)	Individual qualified to participate in a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.
Quality Assurance	The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person or group of persons, locating the problem, correcting the problem, and follow up.
Quality Improvement Organization (QIOs)	Group of practicing doctors and other health care experts paid by the federal government to monitor and improve the care given to Medicare and Medicaid patients. In Arkansas, the QIO is Arkansas Foundation for Medical Care (AFMC), a nonprofit corporation dedicated to the clinical evaluation and improvement of health care in Arkansas. Also known as a Peer Review Organization (PRO).

Health Care Glossary

Term	Definition
Qui Tam Lawsuit	A lawsuit that is basically a civil fraud lawsuit filed by an individual on behalf of the government against companies and individuals that are cheating the government. A law known as the False Claims Act allows whistleblowers to bring qui tam lawsuits. Liable defendants in qui tam cases must pay the government for its losses and pay penalties for fraud. A whistleblower who brings a successful qui tam case under the False Claims Act is entitled to a reward, which is based on the amount of money the government recovers. The False Claims Act also benefits whistleblowers by ensuring them some job protection. Some of the types of fraud against the government that can be the basis of a qui tam lawsuit include Medicare fraud, Medicaid fraud, defense contractor fraud, customs fraud, bid-rigging on government projects, environmental fraud and research fraud. "Qui tam" is short for the Latin phrase – "qui tam pro domino rege quam pro se ipso in hac parte sequitur" – which translates as "he who brings an action for the king as well as for himself" **(See False Claims Act)**.
Rational Drug Therapy	Prescribing the right drug for the right patient, at the right time, in the right amount, and with due consideration of relative cost.
Reasonable and Customary Charge	Charges that represent the range of usual fees for services charged by medical professionals in a geographic area. If the provider charges more than the reasonable and customary fee, the patient will be responsible for paying the difference. Any charges in excess of reasonable and customary will not apply toward the patient's annual out-of-pocket limit.
Rebate	Money that is returned to a payer from a prescription drug manufacturer based upon utilization by a covered person or purchases by a provider.
Referral	An OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor (PCP). If you do not get a referral first, the plan may not pay for your care.
Registered Nurse (RN)	A nurse who has graduated from a formal program of nursing education and has been licensed by an appropriate state authority. RNs are the most highly educated of nurses with the widest scope of responsibility, including all aspects of nursing care. RNs can be graduated from one of three educational programs: two-year associate degree program, 3-year hospital diploma program, or 4-year baccalaureate program.

Health Care Glossary

Term	Definition
Regulations	Rules established under federal Medicare and Medicaid programs and developed through a public process of review and comment. The "minimal" acceptable standards that a facility must comply with to receive reimbursement from the federal (or state) programs. A facility signs a formal provider agreement to meet the established rules. States have their own regulations for long-term care facilities which must be met under the state licensure programs. Regulations also tell states how they must perform their duties, such as how to designate aide training programs, how to administer PASARR (Preadmission Screening and Resident Review program to determine medical necessity for nursing facility placement and need for specialized services), or carry out enforcement activities **(See PASARR)**.
Rehabilitation	The combined and coordinated use of medical, social, educational, and vocational measures for training or retaining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical, and educational.
Reimbursement	The process by which healthcare providers receive payment for their services. Because of the nature of the healthcare environment, providers are often reimbursed by third parties who insure and represent patients.
Residential Care Facility (RCF)	A building or structure used or maintained to provide for pay on a 24-hour basis a place of residence and board for three or more individuals whose functional capabilities have been impaired but do not require hospital or nursing home care on a daily basis, but could require other assistance in activities of daily living.
Respiratory Therapy	The diagnostic evaluation, management, and treatment of patients with deficiencies or abnormalities in the cardiopulmonary (heart-lung) system.
Respite Care	Temporary or periodic care provided in a nursing home, assisted living residence, or at home that allows the usual caregiver to rest or take some time off.
Restraint	Any physical or chemical way to stop a patient from being free to move. Restraints are used to prevent patient injury and are not used for treating medical symptoms. Arkansas is currently number one in the nation in the use of restraints in nursing homes.
Restrictive Formulary	A term often used synonymously with closed formulary.

Health Care Glossary

Term	Definition
Retrospective Review	Determination of medical necessity and/or appropriate billing practice for services already rendered.
Secondary Payer	An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.
Section 1115 Waivers	Section 1115 of the Social Security Act grants the Secretary of Health and Human Services (HHS) broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects. Section 1115 demonstration waivers allow states to change provisions of their Medicaid programs, including: eligibility requirements; the scope of services available; the freedom to choose a provider; a provider's choice to participate in a plan; the method of reimbursing providers; and the statewide application of the program.
Senior Medicare Patrol Projects	Demonstration projects, funded by the Administration on Aging (AoA) and authorized by P.L. 104-209 (the Omnibus Consolidated Appropriations Act of 1997), that utilize the skills and expertise of retired professionals in identifying and reporting error, fraud and abuse. In May 1997, AoA awarded funds to 12 agencies and organizations for this purpose. Based on the success of these activities, AoA now awards grants to 52 projects, operating in 48 states plus Washington, D.C. and Puerto Rico. Volunteers work in their communities and in local senior centers teaching older Americans and their families how to take a more active role in protecting their health care.
Seniors Health Insurance Information Program (SHIIP)	A program within the Arkansas Department of Insurance that is responsible for explaining health insurance programs, especially Medicare supplement insurance choices, to seniors.
Service Area	The geographic area serviced by the health plan, as approved by state regulatory agencies and/or as detailed in the certification of authority.
Side Effect	An unintended problem caused by a drug that has nothing to do with the therapeutic effect. For example, medicine you take for high blood pressure may make you feel sleepy.

Health Care Glossary

Term	Definition
Skilled Nursing Benefit	Medicare Part A (Hospital Insurance) covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Medicare only covers nursing home care for up to 100 days following at least a related 3-day covered hospital stay: Days 1–20: $0 for each day. Days 21–-100: $105 for each day. Days over 101: You pay 100%. There is a limit of 100 days on Medicare.
Skilled Nursing Care	A level of care that must be given or supervised by Registered Nurses (RNs). Examples of skilled nursing care are: getting intravenous injections, tube feeding, administering oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average non-medical person (or one's self) without the supervision of a RN is not considered skilled care. Also, institutional care that is less intensive than hospital care in its nursing and medical service, but which includes procedures whose administration requires the training and skills of a RN.
Skilled Nursing Facility (SNF)	A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.
Social Security Administration (SSA)	The federal governmental agency within DHHS created by the Social Security Act. The SSA administers programs throughout the United States by means of regional offices, divided geographically by districts. These programs include Medicare, SSI, Old Age and Survivor's Benefits, and Disability.
Social Security Disability Insurance (SSDI)	A system of federally provided payments to eligible workers (and, in some cases, their families) when they are unable to continue working because of a disability. Benefits begin with the sixth full month of disability and continue until the individual is capable of substantial gainful activity.
Social Services	The Nursing Home Reform Law (1987) requires that every nursing home provide, either directly or under arrangements, medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The services provided or arranged by the facility must meet professional standards of quality. It also requires that each facility with more than 120 beds employ at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications).

Health Care Glossary

Term	Definition
Social Worker	A person who is licensed, if applicable, by the state, is a graduate of a school of social work accredited or approved by the Council on Social Work Education, and has 1 year of social work experience in a healthcare setting. The Nursing Home Reform Law (1987) requires every nursing facility with more than 120 beds to employ a full-time professional social worker.
Specialist	A doctor who treats only certain parts of the body, certain health problems, or certain age groups.
Specified Low-Income Medicare Beneficiaries (SLMB)	Beneficiaries of a Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.
Spend Down	Under the Medicaid program, a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements. Medicaid eligibility and assets limits differ from state to state.
Spousal Impoverishment	Federal regulations preserve some income and assets for the spouse of a nursing home resident whose stay is covered by Medicaid. If one member of a married couple enters a nursing home, the spouse remaining at home may keep half of their total countable assets (up to the maximum allowable federal standard of $89,280 in Arkansas in 2002. When the total assets are "spent-down" to the one-half reserved for the community spouse, the spouse in the nursing home will be resource eligible and can apply for Medicaid.
State Plan	The Medicaid State Plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with federal requirements.
State Medical Assistance Office	A state agency that is in charge of the State's Medicaid program and can provide information about programs to help pay medical bills for people with low incomes. Also provides help with prescription drug coverage.

Health Care Glossary

Term	Definition
Sub-acute Care	Care provided to patients who are sufficiently stabilized and no longer require acute care services, but are too complex for treatment in a conventional nursing center. Sub-acute care programs typically treat patients who are medically complex and require extensive physiological monitoring, intravenous therapy, or pre- or post-operative care. Care may focus on a specific medical specialty, such as physical rehabilitation, cardiac rehabilitation, wound care, infectious disease care, neurological rehabilitation, orthopedic care, pre- and post-transplant care and pulmonary care, including ventilator care.
Supplemental Insurance	Sometimes called Medigap insurance. A health insurance policy used to cover the "gaps" in Medicare coverage that pays for items such as Medicare deductibles and co-insurance.
Supplemental Security Income (SSI)	A federal Social Security cash assistance program for low-income aged, blind and disabled individuals established by Title XVI of the Social Security Act. The purpose of the program is to provide a basic monthly income to anyone who is 65 or blind or disabled. Eligibility is based on income and assets. States may use SSI income limits to establish Medicaid eligibility. SSI replaced state welfare programs for the aged, blind and disabled in 1972, with a federally administered program, paying a monthly basic benefit nationwide of $284.30 for an individual and $426.40 for a couple in 1983. States may supplement this basic benefit amount.
Supplier	Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.
Temporary Assistance to Needy Families (TANF)	A federal-state welfare program that replaced Aid to Families with Dependent Children (AFDC) that was authorized by the 1996 Welfare Reform Act. States may use TANF to establish Medicaid eligibility.
Therapeutic Alternatives	Drug products containing different chemical entities but which should provide similar treatment effects, the same pharmacological action or chemical effect when administered to patients in therapeutically equivalent doses.
Therapeutic Substitution	Dispensing by a pharmacist of a product different from that which was prescribed, but which is deemed to be therapeutically equivalent. In most states, this requires the prescribing physician's authorization. The rationale for therapeutic equivalency is determined by a pharmacy and therapeutics committee (P&T).

Health Care Glossary

Term	Definition
Third Party Payer	A public or private organization that pays for or underwrites coverage for healthcare expenses or another entity, usually an employer (examples: Blue Cross, Blue Shield, Medicaid, and commercial insurers).
Title III Services	Services provided to individuals age 60 and older which are funded under Title III of the Older Americans Act. They include: congregate and home-delivered meals; supportive services (e.g., transportation, information and referral, legal assistance, and more), in-home services (e.g., homemaker services, personal care, chore services, and more); and health promotion/disease prevention services (e.g., health screenings, exercise programs, and more).
Title XVIII (Medicare)	Federal health insurance program for persons age 65 and over and certain disabled persons under age 65. Consists of 2 parts: Part A (hospital insurance) and Part B (optional medical insurance which covers physicians' services and outpatient care in part and which requires beneficiaries to pay a monthly premium).
Title XIX (Medicaid)	Joint federal- and state-funded program of medical assistance to low-income individuals of all ages.
Title XX Services	Grants given to states under the Social Security Act which fund limited amounts of social services for people of all ages (including some in-home services, abuse prevention services, and more). Now known as *Social Services Block Grant services.*
Treatment Options	The choices you have when there is more than one way to treat your health problem.
Transfer of Assets	Transfer of a potential Medicaid recipient's money or possessions to a third party. Medicaid regulations govern time frames and conditions under which individuals may transfer assets to others without jeopardizing Medicaid eligibility. In Arkansas, it is 3 years.
TRICARE	TRICARE is the healthcare program for active-duty members of the military, military retirees, and their eligible dependents. TRICARE was previously called CHAMPUS (Civilian Health and Medical Program).
Unbundling	Billing related services separately to charge a higher amount than if they are combined and billed as one service, group of services, or panel of services.
Undue Hardship	With respect to the provision of accommodation for an individual with a disability under the Americans with Disabilities Act (ADA) – significant difficulty or expense, considered in light of the employer's financial resources, facilities, workforce, and business operations.

Health Care Glossary

Term	Definition
Upcoding	Altering claim forms to obtain a higher payment amount. Misuse of the standardized system of numerical codes for patient services to increase the bill by exaggerating or even falsely representing what medical conditions were present and what services were provided. Billing for a more expensive, Medicare or Medicaid covered item when a less expensive, non-covered item was provided.
Utilization	The extent to which the members of a covered group use a program or obtain a particular service or category of procedures over a given period of time. Usually expressed as the number of services used per year or per 100 or 1,000 persons eligible for the service.
Utilization Review (UR)	A formal assessment of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans on a prospective, concurrent or retrospective basis.
Vendor	A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical products and/or services either to a medical provider, who in turn interfaces with patients, or directly to the public. A term common to the Medicaid program.
Vital Statistics	Statistics relating to births (natality), deaths (mortality), marriages, health, and disease (morbidity).
Walker	A lightweight frame held in front of a person to give stability in walking. It offers more stability than a cane.
Waiver	A rider or clause in a health insurance contract excluding an insurer's liability for some sort of pre-existing illness or injury. Also, a plan amendment, such as a CMS waiver or plan modification to allow a state to expand Medicaid coverage or change the rules under which it provides Medicaid services.